PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445439	A. BUILDING _____ B. WING _____	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT JULIET HEALTH CARE CENTER	2850 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During a Recertification Survey, and Complaint Investigation for TN-31980, TN-31757, TN-31756, TN-31730, TN-31695, and TN-31615, conducted July 22 to July 24, 2013, no deficiencies were cited in relation to the complaints under 42 CFR Part 482.13 Requirements for Long Term Care.	F 000		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding	F 272	F 272 483.20 (b) (1) COMPREHENSIVE ASSESSMENTS SS=D Requirement: The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by State. The assessment must include, at least, the following: identification and demographic information; customary routine; cognitive patterns; communication; vision; mood and behavior pattern; psychosocial well-being; physical functioning and structural problems; continence; disease diagnosis and health conditions; dental and nutritional status; skin conditions; activity pursuit; medications; special treatments and procedures; discharge potential; documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and documentation of participation in assessment.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 8/6/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 272	Continued From page 1 the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview the facility failed to assess one resident (#137) receiving dialysis treatments for one resident reviewed on dialysis (The mechanical process of removing waste products from the blood in the absence of effective kidney function). The findings included: Resident #137 was admitted on June 10, 2013, with diagnoses including End Stage Renal Disease, Complex Partial Seizures, Hypothyroidism, Malnutrition, Hypertension, and Diabetes. Medical record review of the Minimum Data Set (MDS) dated June 24, 2013, revealed the resident required minimal assistance with one person for bed mobility, transfers, and ambulation in the hallway. Continued MDS review revealed the resident scored 14 out of 15 on the Brief Interview for Mental Status indicating no cognitive impairment. Review of the Nurse's Admission/Readmission	F 272	Corrective Action: The facility will conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. 1.Resident #137 was discharged from the facility with home health services on 7/24/13. 2.There are currently no other residents residing in the facility that receive dialysis services. The nursing staff was in-serviced on 7/24/13 and 8/6/13 by the DON & ADON regarding the facility guidelines for assessing patients on dialysis and the required documentation. 3.As patients are admitted to the facility that need dialysis services, the charge nurses will perform required assessments and documentation according to facility guidelines. The staff development coordinator will make sure the guidelines for patients on dialysis are included in the new hire orientation process. 4.Nurse management and the QA Committee will monitor the medical records of all new admissions on dialysis and will monitor the orientation documentation for new hired nurses weekly X 4, then monthly X 6 to ensure compliance. The corrective action plan will be modified as indicated, to establish compliance.	8/6/13

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F 272	Continued From page 2 Assessment dated June 10, 2013, revealed "... Admission Note:..Res (resident) has port on upper R (right) chest. On dialysis. End Stage Renal Failure..." Review of the Daily Skilled Nurses Notes dated July 17 (Wednesday), July 19 (Friday), and July 22, 2013 (Monday), revealed the resident was out of the facility on all three days for dialysis. Continued review of the same nurse's notes revealed no documentation the resident was assessed upon return to the facility after receiving dialysis treatment. Review of the facility policy, Dialysis Patient Services, revealed, "...There are several special interventions to be implemented with a patient receiving dialysis...5...Condition of patient before dialysis and upon return; Consumption of and adherence to diet..." Interview with the resident on July 22, 2013, at 3:27 p.m., in the resident's room, confirmed the resident received outpatient dialysis treatments for end stage renal disease on Monday, Wednesday, and Friday of each week. Interview on July 24, 2013, at 1:33 p.m., at the nurse's station, with Licensed Practical Nurse (LPN) #3 who was present on the days the resident returned from dialysis confirmed the resident had not been assessed after receiving dialysis. Continued interview with LPN #3 confirmed LPN #3 had no knowledge of the assessment documentation required for residents receiving dialysis. Interview with the Assistant Director of Nursing on July 24, 2013, at 1:45 p.m., at the nurse's station,	F 272		

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F 272	Continued From page 3 confirmed the facility policy was not followed for assessment of residents receiving dialysis.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to care plan for anticoagulant (blood thinning) medication interventions for one resident, # 91, of forty-one residents reviewed. The findings included: Resident # 91 was admitted to the facility on June 14, 2013 with diagnoses including Atrial	F 279	F 279 483.20(k)(1) DEVELOPMENT OF COMPREHENSIVE CARE PLANS SS=D Requirement: A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive plan of care for each resident that includes measureable objectives and time tables to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practical, physical, mental, and psychosocial well-being as required under 483.25; and any services that would otherwise be required under 483.25 but are not provided due to the resident's exercise of rights under 483.10, including the right to refuse treatment under 483.10(b)(4). Corrective Action: The facility will use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	

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F 279	Continued From page 4 Fibrillation, Hypertension, Status Post Cardiac Pacemaker, Type 2 Diabetes, and Hypoxemia. Medical Record Review of the Medication Administration Records (MAR) for June and July, 2013, revealed the resident was prescribed Coumadin (an anticoagulant medication). Continued review revealed the Coumadin dosage was adjusted on June 21, June 27, July 5, and July 9, 2013. Medical record review of the Plan of Care dated June 14, 2013, revealed no nursing interventions, or precautions related to anticoagulant therapy present. Interview with the Assistant Director of Nursing, on July 24, 2013, at 10:40 a.m., in the nursing station, confirmed the facility failed to care-plan Nursing interventions specific to anticoagulant therapy for the resident.	F 279	1.The care plan for resident #91 was updated on 7/24/13 to reflect nursing interventions and precautions related to anticoagulant therapy. 2.The care plans for each resident on anticoagulant therapy has been reviewed and updated, when indicated on 7/25/13. The MDS Coordinator was in-serviced on 7/25/13 by the DON regarding facility guidelines for developing, reviewing and revising resident's care plan. 3.The MDS coordinators will develop, review and revise resident's care plans according to facility guidelines to ensure nursing interventions and precautions are current and appropriate. 4.Nurse management and the QA Committee will monitor the care plans for patients on anticoagulant therapy monthly to ensure compliance and modification will be made to the corrective action plan as indicated, to establish compliance.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of	F 280	**F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE – REVISE CP** **SS=D** **REQUIREMENT:** The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state, to participate in planning care or treatment or changes in care or treatment.	7/25/13

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F 280	Continued From page 5 the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to revise the Care Plan for two residents (#79 and #92) of forty one residents reviewed. The findings included: Resident #79 was admitted to the facility on August 3, 2009, with diagnoses including Dementia, Behavioral Signs/Symptoms, Status Post Right Hip Fracture, Osteoporosis, Degenerative Joint Disease, and Anxiety. Medical record review of a Nurse's Event Note dated July 6, 2013, revealed "...Nurse heard alarm sounding and went into room and found resident on the floor of bathroom in front of wheelchair...Resident picked up and put on the commode..." Medical record review of the current Care Plan reviewed by the facility on July 6, 2013, revealed the care plan had not been revised with new interventions for fall precautions after the resident had fallen. Interview with Director of Nursing on July 24, 2013, at 7:36 a.m., in the DON's office, confirmed the Care Plan had not been updated or revised to	F 280	A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident and other appropriate staff in disciplines as determined by the resident's needs, and to the extent, practical, the participation of the resident, the resident's family, or the residents' legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. **Corrective Action:** The facility will ensure that the resident's right to participate in the care planning process is maintained unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state. 1.The care plan for resident # 79 was updated on 7/25/13, to reflect appropriate interventions and precautions for the fall that occurred on 7/6/13. The care plan for resident # 92 was updated on 7/24/13 to accurately reflect the resident's pressure ulcers, location and sites.	

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F 280	Continued From page 6 reflect new interventions for fall precautions. Resident (#92) was admitted to the facility on April 14, 2010, with diagnoses including Transient Ischemic Attack, Right Cerebral Infarct with Left sided Weakness, Hypertension, Diabetes, and Dementia. Medical record review of the Medical Administration Record (MAR), for July 2013, revealed, "...clean r (right) heel with NS (normal saline), pat dry, apply collagen, cover with border foam change q (every) day, "...clean r malleolus with w/c (wound cleanser) apply skin prep until resolved DTI (deep tissue injury) ...Dermaphor oint (ointment) apply topically to BLE (bilateral lower extremities) BID (two times a day) prn (as needed), clean r foot toes with w/c apply TAO (topical antibiotic ointment), leave OTA (on toes absorbed) until resolved, wkly (weekly) skin check q sun (Sunday) 3-11..." Medical record review of the Weekly Wound Progress Note dated June 14 to July 24, 2013, revealed the resident had a deep tissue injury with an onset date of June 20, 2013. Medical record review of the Care Plan dated and implemented August 28, 2012, revealed the resident had a deep tissue injury on the right malleolus beginning May 24, 2013, and no pressure ulcer on the right heel. Interview with Licensed Practical Nurse (LPN #5) on July 24, 2013, at 10:00 a.m., at the nursing	F 280	2.An audit of care plans has been conducted on 7/28/13 by nurse management for residents with pressure ulcers and falls. The care plans and documentation will be reconciled for accuracy by 8/15/13. The MDS Coordinator was in-serviced on 7/25/13 by the DON regarding developing, reviewing and revising care plans to ensure they are accurate and current. The treatment nurses was in-serviced on 7/28/13 and 8/8/13 by the DON regarding facility guidelines for accurate measuring, staging and documenting pressure ulcers. 3.The MDS Coordinator will review the care plans weekly for those residents with falls and pressure ulcers to ensure they reflect accurate and current information. The Treatment nurse will ensure documentation for pressure ulcers meet the facility's guidelines weekly. 4.Nurse management and the QA Committee will monitor 50% documentation and care plans for residents with falls and pressure ulcers weekly X 4 then 10% monthly to ensure compliance. The corrective action plan will be modified as indicated.	8/15/13

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F 280	Continued From page 7 station, confirmed the resident did not have any pressure ulcer on the right malleolus, had a pressure ulcer to the right heel with an onset date of June 14, 2013, and the care plan had not been revised to accurately reflect the resident's pressure ulcers.	F 280		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to timely and accurately assess the pressure ulcers of resident (#92) of forty-one residents reviewed. The findings included: Resident #92 was admitted to the facility on April 14, 2010, with diagnoses including Transient Ischemic Attack, Right Cerebral Infarct with Left sided Weakness, Hypertension, Diabetes, and Dementia. Medical record review of the Quarterly Minimum	F 314	F 314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES SS=D REQUIREMENT: Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	

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F 314	Continued From page 8 Data Set dated May 28, 2013, revealed the resident had severely impaired cognition and one unstageable deep tissue injury. Medical record review of the Care Plan dated August 28, 2012 and revised March 8 and June 5, 2013, revealed the resident had a reoccurring right heel ulcer which was resolved on October 1, 2012, and again resolved on March 21, 2013. Further review revealed the resident had a deep tissue injury to the left heel on March 21, 2013, and resolved April 21, 2013. Further review revealed on May 24, 2013, the resident had a deep tissue injury to the right malleolus (ankle). Further review revealed "...refer to weekly wound documentation & (and) physician orders for current skin issues...". Medical record review of the Non-Ulcer Weekly Progress Note revealed wound assessments were completed May 24, May 31, June 9, June 24, July 2, and July 7, 2013 for a deep tissue injury on the right malleolus. Medical record review of the Weekly Wound Progress Note revealed assessments were completed on June 14, June 20, June 21, July 2, and July 7, 2013 for an unstageable wound on the right heel with an onset date of June 20, 2013. Medical record review of the weekly wound progress note dated June 20, 2013, revealed the right heel was documented as a stage III measuring 2.4 centimeters (cm) by 1.8 (cm) with a depth of less than 0.2 (cm). Medical record review of the Weekly Wound Progress Note dated June 21, 2013, revealed the	F 314	Corrective Action: The facility will ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. 1.The pressure ulcer of resident # 92 was accurately re-assessed on 7/24/13 and the documentation and care plan was updated accordingly. 2.The treatment nurse was in-serviced on 7/28/13 and 8/8/13 by the DON on the facility guidelines for measuring, staging and documenting pressure ulcers. All pressure ulcers has been re-assessed on 7/28/13 by a visiting treatment nurse and the documentation will be reviewed/revised for accuracy, consistency and timeliness by 8/15/13. 3.The treatment nurse will complete weekly pressure ulcer assessments and required documentation according to facility guidelines. 4.Nurse management and the QA Committee will monitor 100% of pressure ulcer documentation weekly X 4, then 50% monthly for compliance. The corrective action plan will be modified as indicated, to establish substantial compliance.	8/15/13

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F 314	Continued From page 9 right heel was documented as a deep tissue injury appearing as a stage II measuring 2.4 (cm) by 1.8 (cm) with a depth of less 0.2 (cm). Medical record review of the residents Care Plan, physician's orders, wound progress notes, treatment record, and nursing notes for May and June, 2013, revealed the wound to the right malleolus was discovered May 21, 2013, treatment orders were obtained and implemented appropriately, and the wound was still present on the right malleolus. Further review revealed treatment for the wound on the right heel began on June 14, 2013. Observation of the resident's right foot on July 24, 2013, at 8:40 a.m., with Licensed Practical Nurse (LPN #5) in the residents room, revealed the resident had a pressure ulcer described as "unstageable" on the right heel measuring 5.5 (cm) by 4.5 (cm) with unable to determine depth due to eschar (black, hard coating). Further observation revealed no visible wound to the right malleolus. Interview with LPN #5 on July 24, 2013, at 10:00 a.m. at the nursing desk, and review of the medical record with the LPN, confirmed the resident had a reoccurring unstageable pressure ulcer to the right heel with physicians orders and appropriate treatment for an unstageable pressure ulcer implemented on June 14, 2013. Continued interview and medical record review confirmed the resident did not have a pressure ulcer to the right malleolus, there were no orders or notes indicating when the right malleolus ulcer had resolved and weekly assessments had not been performed. Continued interview and medical record review confirmed the wound	F 314		

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F 314	Continued From page 10 progress notes indicated the right heel wound developed on June 20, 2013, but physician's orders indicated the wound had an onset date of June 14, 2013. Continued interview and medical record review confirmed the wound progress note assessments for June 20 and 21, 2013 were not accurate and consistent, and weekly assessments had not been completed. Continued interview confirmed weekly assessments of wounds had not been completed accurately and consistently.	F 314		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure one resident (#31) had a wrist splint in place. The findings included: Resident #31 was admitted to the facility on April 10, 2013, with diagnoses including Seizure Disorder, Hypertension, Depression, Dementia with Senile Psychosis, and Congestive Heart Failure. Medical record of a physician's order dated May	F 318	F318 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION SS=D Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Corrective action: The facility will ensure that a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. 1. Resident #31 was assessed by the orthopedic on 7/9/13 for the use/need of the wrist splint, and a new order was received to D/C the wrist splint as recorded in the nurses notes. The MD order to D/C the splint was written on 7/29/13 and the care plan was updated to reflect the change.	

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	445439	A. BUILDING _____ B. WING _____	07/24/2013

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F 318	Continued From page 11 28, 2013, revealed the resident was to have a splint on the left wrist. Medical record review of the July 2013, recapitulation orders revealed the resident was to wear a splint on the left wrist. Observation on July 23, 2013, at 4:15 p.m., revealed the resident was in the wheelchair sitting in the hallway with no splint on the left wrist. Observation on July 24, 2013, at 8:40 a.m., revealed the resident was wheeling self-down the hallway, with no splint on the left wrist. Observation on July 24, 2013, at 10:40 a.m., revealed the resident was sitting in the activity area and was not wearing a splint on the left wrist. Observation and interview on July 24, 2013, at 12:45 p.m., with Registered Nurse #2 (RN) revealed the resident should be, but was not wearing the left wrist splint.	F 318	2.The nursing staff was in-serviced on 7/26/13 and 8/8/13 by the DON regarding adhering to and processing physician's orders when received according to facility guidelines. The medical record for other residents with splints ordered was audited on 7/28/13 to ensure residents with splints have appropriate physician's orders in place. 3.The nursing and restorative staff will make sure that splints are applied as indicated by the resident's care plan and in accordance with the facility guidelines. The restorative team was in-serviced on 8/5/13 by the DON regarding their responsibility in the process for managing residents splints. The nursing staff will process physician's orders when received according to facility guidelines. 4.Nurse management and the QA Committee will monitor the medical record for those resident's with splints weekly X 4, then 10% monthly X6 and ensure compliance with facility guidelines. The corrective action plan will be modified as indicated, to establish substantial compliance.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323	**F323 483.25(h) FREE OF ACCIDENTS/HAZARDS/SUPERVISIONS/ DEVICES** **SS=D** The facility must ensure that the resident's environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	8/15/13

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F 323	Continued From page 12 by: Based on medical record review, observation, review of facility investigation, and interview, the facility failed to implement interventions after a fall for one resident (#79) out of forty one residents reviewed, and failed to secure hazardous chemicals in the beauty shop. The findings included: Resident #79 was admitted to the facility on August 3, 2009, with diagnoses including Dementia, Behavioral Signs/Symptoms, Status Post Right Hip Fracture, Osteoporosis, Degenerative Joint Disease, and Anxiety. Medical record review of the Quarterly Minimum Data Set dated May 20, 2013, revealed the resident had severely impaired cognition; required extensive assistance of two plus persons for transfers and toileting; and had not had any falls since the last assessment. Medical record review of a Nurse's Event Note dated July 6, 2013, revealed "... Nurse heard alarm sounding and went into room and found resident on the floor of bathroom in front of wheelchair...Resident picked up and put on the commode..." Further review revealed the resident did not have any injuries. Medical record review of the current Care Plan reviewed by the facility on July 6, 2013, revealed the care plan was updated to indicate the resident had a fall on July 6, 2013, but no new interventions had been added to the care plan. Review of the Facility's investigation for the fall on July 6, 2013, revealed interventions put in place	F 323	Corrective Action: The facility will ensure that the residents environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 1.The fall for resident # 79 was thoroughly investigated and a new intervention and precaution was implemented on 7/31/13, and the care plan was updated accordingly. The facility secured and/or removed hazardous chemicals and supplies behind lock and key in cabinets stored in the beauty shop on 7/22/13. 2.An audit of care plans for falls was conducted on 7/30/13 by nurse management, for appropriate nursing interventions and precautions. The care plans will be updated with appropriate interventions and precautions by 8/15/13. The nursing staff was in-serviced on 8/7/13 by the DON regarding thoroughly investigating resident falls, how to identify the root cause and implementing an appropriate intervention timely. The beauty shop was inspected by the Administrator randomly between 7/22/13 and 8/1/13 to ensure cabinets were properly locked and all chemicals were properly stored.	

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F 323	Continued From page 13 were to place the resident in the hallway after the fall and to supervise the resident while toileting. Interview with the Director of Nursing on July 24, 2013, at 8:10 a.m., at the nurse's station, confirmed the facility failed to do a thorough investigation for the fall and failed to implement new interventions for fall precautions. Observation on Monday, July 22, 2013, at 10:00 a.m., in the beauty shop located on the 400 wing, revealed an unlocked door. Posted days of use for the beauty shop were Tuesday, Wednesday, and Thursday. Observation inside the unlocked beauty shop revealed a container of Barbicide liquid and combs without the lid. Continued observation revealed a variety of unsecured chemical hair products. The back of the room revealed an area for central supplies which consisted of two cabinets, one of which was unlocked. Inside the unlocked cabinet was one bottle of hydrogen peroxide, Xeroform bandages and sterile dressing supplies. Interview on July 22, 2013, at 10:10 a.m., in the Beauty Shop with the acting Administrator, confirmed the door was unlocked and hazardous chemicals and supplies were not secured.	F 323	3.The MDS Coordinator will review the care plans weekly for those residents with falls and ensure they reflect appropriate interventions and precautions to reduce fall risk. The maintenance director changed the door handle on the beauty shop on 8/1/13 to an automatic locking handle requiring entry by key only. 4.Nurse management and QA&A Committee will monitor care plans for residents who has had falls weekly X 4 then 50% monthly to ensure compliance. The Administrator, nurse management and QA Committee will conduct random facility rounds weekly X 12 to ensure all chemicals and supplies are stored properly in the beauty shop. The corrective action plan will be modified as indicated to obtain and maintain substantial compliance.	8/15/13
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	**F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS SS=D** **Requirement:** The facility must establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	

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F 441	Continued From page 14 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and interview the facility failed to maintain infection control and failed to follow practices to prevent the spread of infection. The findings included:	F 441	Corrective Action: The facility will establish and maintain an infection control program designed to provide safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. 1. The staff present during survey was in-serviced on 7/22/13 and 7/23/13 by the DON regarding hand hygiene and good hand washing according to facility guidelines. 2.All other staff will be in-serviced by 8/15/13 by the DON regarding hand hygiene and good hand washing according to facility guidelines. 3. The staff will follow facility guidelines for universal precautions, good hand washing and hand hygiene techniques to help prevent the spread of disease and infection. The facility guidelines will be reviewed in new hire orientation with return demonstration. 4.Nurse management and QA Committee will randomly observe staff weekly during medication administration and performing treatments to ensure universal precautions, good hand hygiene and hand washing is maintained according to facility guidelines. The corrective action plan will be modified if recommended by the QA Committee.	8/15/13

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F 441	Continued From page 15 Review of the facility's policy Infection Control, General, Hand Hygiene revealed ...hand hygiene must be performed at a minimum:"...before donning gloves and after removing gloves." Observation on July 22, 2013, at 10:15 a.m., in the three hundred hallway, revealed Licensed Practical Nurse #1 (LPN) administering medications to a resident wearing gloves. Continued observation revealed the nurse exited the resident's room, removed gloves, returned to the medication cart, opened the medication drawer, retrieved clean medication, without disinfecting the hands. Interview with LPN #1 on July 22, 2013, at 10:25 a.m., in the hallway, confirmed the LPN had not disinfected the hands after glove removal. Resident (#92) was admitted to the facility on April 14, 2010, with diagnoses including Transient Ischemic Attack, Small Right Cerebral Infarct with Left Sided Weakness, Hypertension, Diabetes, and Dementia. Observation on July 24, 2013, at 8:30 a.m., in the resident's room, revealed Licensed Practical Nurse (LPN) #5 washed the hands, obtained the supplies from cart, opened the lid of the trash can on the cart to put items in the trash, then touched the lid to close it, and proceeded to gather the clean supplies. LPN #5 then touched the trash lid again and opened the foam dressing, cut dressing with scissors and then placed the remainder of the dressing in the trash, touching the lid to close it.	F 441		

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F 441	Continued From page 16 Interview with LPN #5 on July 24, 2013, at 9:15 a.m., outside the resident's room, confirmed the trash can lid was considered dirty and hand hygiene should have been performed.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to ensure the medical record was complete for pain assessments for one (#42) resident and a physician's order was obtained for the use of a BiPAP (respiratory breathing equipment) for one resident (#103) of forty-one resident's reviewed. The findings included: Resident #42 was admitted to the facility on July 17, 2008, with diagnoses including Chronic Liver Disease and Cirrhosis, Senile Delusion, Senile Depressive Disorder, Osteoarthrosis, Anxiety,	F 514	F514 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE SS-D REQUIREMENT: The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the state; and progress notes. Corrective Action: The facility will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	

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F 514	Continued From page 17 Status Post Left Knee Replacement, Hiatal Hernia, Rheumatoid Arthritis, and Fractured Pelvis. Medical record review of the Medication Administration Record (MAR) and Pain Assessment Flow Sheet revealed the facility did not document the resident's pain levels on the Pain Assessment Flow Chart for the months of June 2013, and July 2013. The resident received Hydrocodone/APAP (pain medication) 10/325 four times a day. Review of the facility's Pain Management Policy revealed "...The Pain Assessment Flow Chart is to be utilized for any complaints or signs and symptoms of pain..." Interview with the resident on July 24, 2013, at 9:40 a.m., in the residents room revealed, " ...still has pain daily but pain is regulated every four hours. The medicine helps." Interview with the Director of Nursing (DON) on July 24, 2013, at 1:25 p.m., in the DON office confirmed there was no documentation of pain levels on the Pain Assessment Flow Chart for the months of June 2013, and July 2013. Resident #103 was admitted to the facility on March 3, 2013 with diagnoses including: Chronic Obstructive Pulmonary Disease (COPD), Asthma, Chronic Atrial Fibrillation (irregular heart rate), Diabetes Mellitus type 2, Chronic Kidney Disease, Morbid Obesity, Renal Cancer, Anemia and Depression. The resident was discharged from the facility on March 26, 2013. Review of the admission Minimum Data Set (MDS), dated March 3, 2013, revealed the	F 514	1.The charge nurse assessed resident's pain to determine pain level and effectiveness of pain medication and document results according to facility guidelines. Resident # 103 was discharged home on4/26/13. 2.Every resident on scheduled pain management will be assessed to determine pain levels and effectiveness of the scheduled medication regimen and document according to facility guidelines. An audit of the medical records for residents with BIPAP/CPAP in use was conducted on 7/28/13 to ensure physician's orders were properly in place according to facility guidelines. 3.The charge nurses was in-serviced on 8/8/13 by the DON regarding facility guidelines for pain management and required documentation. The charge nurses will assess and document each resident's pain levels and the effectiveness of the pain medication regimen according to facility guidelines. The nurses were in-serviced on 8/7/13 by the DON regarding facility guidelines for obtaining physician's orders for all care and services and processing accordingly. 4.Nurse management and the QA Committee will monitor medical records and perform random resident interviews weekly X4 then monthly to determine compliance. The correction action plan will be modified as indicated to establish compliance.	8/15/13

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F 514	Continued From page 18 resident scored a 15 on the Brief Interview for Mental Status, indicating the resident was cognitively intact and did not require any assistance with activities of daily living. Medical record review of the physician's admission orders, dated March 3, 2013 revealed an order for "...O2 (oxygen) 2-4 L (liters), as needed; contact MD (medical doctor) for further direction..." Continued review of the physician's orders revealed no written order for the BiPAP machine (machine used to assist with breathing). Medical record review of a nurse's note, dated April 25, 2013, revealed "...reeducated on keeping O2 in use and wearing BiPAP at night..." Interview with Registered Nurse (RN) #3, on July 24, 2013, at 12:30 p.m., in the Director of Nursing (DON) office, revealed the RN was on the floor the day of the discharge of the resident. Continued interview revealed the resident wore the BiPAP at home and the BiPAP was being used while at the facility. Interview with the DON, on July 23, 2013, at 12:35 p.m., in the DON office, confirmed the facility failed to obtain a physician's order for the use of the BiPAP machine.	F 514		